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ABSTRACT

Both clinicians and patients can easily become entangled in the "rights versus rites" debate--that is, the effort to strike a balance between mandated "right to treatment" and emerging "right to refuse treatment." This paper examines legal and psychiatric precedent and practice in those areas and suggests a practical, prudent and palatable middle ground in solving that crucial dilemma. (Author)

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THE BALANCING ACT: TREATMENT RIGHTS AND LEGAL "RITES"

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William Wrigley once said, in speaking of administrative style, "If two people in an organization always agree with each other, one of them is unnecessary". I subscribe to that administrative style. If one thinks of the organization as being as broad as "mental health", then, applying Wrigley's (and mine) philosophy, the differing viewpoints between attorneys and clinicians in a number of areas in the complex interface between psychiatry and the law are not only understandable, but necessary, acceptable, and healthy. It should come as no surprise, given the different background, perspective, and duties of the attorney and the clinician with respect to the patient/client, that at times there are differences of opinion as to the relative importance, or ranking, of clinical realities and legal rights. That these differences exist is not surprising. That these differences be bridged, balanced, and gulfed on some "reasonable middle ground" taxes the ingenuity, imagination and effort of each of us in Psychiatry and the Law. There is a "reasonable middle ground" in each of these troublesome, and troubling questions, and our efforts must be directed at finding that reasonable meeting point. I welcome then the opportunity to be part of this panel, seeking the reasonable boundaries of legal intervention in mental health. Indeed, there is a basis for creative, therapeutic relationships between Law and mental health. Witness, in fact, this panel.

My interest in this delicate balancing act began, unbeknownst to me, in March, 1958 on a steel cold winter morning in Wisconsin where I was doing a preceptorship in the fourth year of medical school. I had the unpleasant task of watching a young boy die of heart disease. I had been assigned to wait for the heart to beat its final stroke, at which time I was to take a needle and get a sample of blood from

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the left ventricle to measure electrolytes for a clinician--the boy's doctor--who was interested in electrolyte levels in this particular disorder. As I stood there that long night and watched that little boy's life slip away, and as I watched the grief and agony of his parents in this awful moment, it seemed to me that I, and everyone else there, was missing the point of that whole human predicament; more was at stake than a rearrangement of electrolytes. But the boy did die. Dutifully I got the blood sample. The doctor in charge was pleased, not that the little boy died, of course, but that he died with his electrolytes entirely in order. That seemed, to me, to be an empty chemico-clinical triumph.

I tucked that away in my mind, wherever you tuck things like that, until 1970. At that time the Lessard decision was handed down in Wisconsin which indicated that the sole criterion for involuntary hospitalization was "*extreme likelihood* that if a person was not confined he would do *immediate physical* harm to himself or others". It was following the Lessard decision that cases began to come to my attention in Wisconsin and elsewhere where patients "died with their rights on"--situations where scrupulous concern for the patient's rights outweighed reasonable concern for the patient's life.[1-3] In addition to those persons actually "dying with their rights on", other kinds of problems, as well, surfaced from using commitment criteria too harsh and too stringent. For example, some patients were required to deteriorate until they accumulated sufficient symptoms to meet the dubious qualification of being dangerous as evidenced by a recent overt act. Others were imprisoned--criminalized--instead of simply being hospitalized. Jail populations in some areas rose drastically, as much as three-fold, because of patients who, failing commitment, were picked up for loitering or disorderly conduct.[4] Recent work I have been doing, and work which will be reported at the American Psychiatric Association Annual Convention in Atlanta in May, 1978, documents the sizable increase of patients coming into the mental health system as criminals--booked on minor charges such as disorderly conduct, vagrancy, shoplifting--and sent to a

psychiatric hospital either for observation on a criminal charge, or as unable to stand trial, again on a criminal charge. There has been a rise of 78% system-wide in Wisconsin of such criminal observation cases, and a 260% increase in our facility of these criminal observations.[5] At a time when we are seeking to decriminalize the alcoholic, and decriminalize the marihuana user, we are re-criminalizing the mentally ill--a stance we had, I thought, abandoned two hundred years ago. A look at our forensic unit now--psychotic persons criminalized, prevented and prohibited from receiving treatment that predictably would ameliorate their condition--is to look at the mental health clock set back two hundred years.

These situations bring back to my mind that steel cold night in Wisconsin. These instances--and they continue and continue to occur--show what can happen when scrupulous concern for the patient's rights overshadows or outweighs reasonable concern for the patient's life. To me, like that empty chemico-clinical triumph, these instances represent a dubious and hollow legal triumph.

Simply stated, it is my position that the *freedom* to be penniless, helpless and senseless, and seizuring in a bus station, for example, as one of my patients was, is not freedom at all--it's abandonment. The *right* to be demented, agonized, and terrorized in the face of treatment which cannot, because of legal prohibition, be applied is no right at all--it's a new form of imprisonment. The *liberty* to be naked in a padded cell with a cork floor, hallucinating, delusional, tormented, is not liberty--it is a folie a deux among pseudo-sophisticated liberals and an unrealizing public. A shared delusion that by changing the name of something to whatever, or substituting a jail for a hospital, or passing a law against something, one has done something significant, or even magnificent.

In a very specific sense, however, for the be-legaled clinician, and his or her patient, the cutting edge of the rights vs. rites debate--rhetoric and philosophicizing aside--is the balancing act between mandated "right to treatment" and the emerging "right to refuse treatment". Talk about being between a rock and a

hard place, it seems incredible, even preposterous, that I find myself in the position of having (a) the responsibility to treat a patient committed by the court to me for "custody and treatment"; yet (b) finding the patient refusing the very treatment which will ameliorate the treatment for which he is committed; then (c) being threatened with "right to treatment" suit because the patient is not receiving treatment. That's not a balancing act, that's a new form of insanity.

Perhaps it would be helpful at this point to tell where I am coming from in this whole issue. First of all, what I am not. I am not a mental hospital superintendent in need of a job. I am not in public practice because I feel I cannot survive in private practice. I am not an "organic" psychiatrist. I do not believe that psychotropic drugs are the answer to all of mankind's ills. I do not believe in using my professional or personal power to shape the lives of patients irrespective of their persuasion or wishes. I do not believe myself to be so all-knowing and omnicient as to inflict my will or knowledge on unsuspecting patients under the guise of parens patriae.

Some words about what I am. I am a psychiatrist who feels that the public mental hospital does have a role to play in the treatment of specialized, and especially complex, psychiatric patients whose treatment needs exceed local capability. I feel that the public mental hospital, like a university hospital, has a unique and important role complementary to, but not distinguished from, the private hospital or private practice of psychiatry. I feel that mental illness is a complicated entity involving biological as well as social and psychological factors. Patients should be treated in the least restrictive environment possible commensurate with their treatment needs. And finally, I believe major mental illness to be a biological or biochemical disorder, probably stress induced, which in most instances will respond to treatment with psychotropic drugs properly and appropriately chosen in correct doses, such that the patient can be maintained free of

symptoms in the same manner as the diabetic, the arthritic, the hypertensive, the person with Addison's Disease, etc. can be free of symptoms (albeit not cured). I believe finally that there is a reasonable middle ground between clinical realities and legal rights, and that it is entirely possible for the pendulum to swing too far in either direction, and it is our opportunity, as well as responsibility, to find that reasonable middle ground.

Professor Alexander D. Brooks gives a good overview of the problem of the right to refuse treatment.[6] He points out the two sides of the coin: (1) If the purpose of hospitalization is treatment rather than removal from society, how, then, can the right to refuse treatment be supported? vs. (2) Unless there is a specific decision made about competency, one can use treatment only in emergency situations, and the patient has an absolute right to refuse treatment. In support of (1) above, Brooks points out that one court, ruling in a suit brought for damages by a former mental patient who while hospitalized for twelve years was never treated with anti-psychotic drugs, that "the reason for not using such drugs was the plaintiff refused them. We consider such reason to be illogical, unprofessional, and not consonant with prevailing medical standard." Brooks then, in a well considered argument and presentation, points out the difference between "customary" and "non-customary" treatments, and implies that in cases where there had been a judicial determination of incompetence, customary treatments may be used. Customary treatment is used to describe those medical treatments that are regarded by both Medicine and Law as routinely acceptable because the benefit resulting from the treatments significantly outweighs the cost. Brooks further points out that many commentators view the position of the absolute refusal of treatment to be absurd, reasoning that hospitalization without the power to treat is an act of futility, and that the act of hospitalizing a mentally ill person necessarily implies a concomitant authority, even an obligation, to treat, regardless of whether the statute requires a determination about impaired judgment.

Generally, to this point, the arguments around the right to refuse treatment have narrowed to the psychotropic drugs. For purposes of this discussion, I will narrow the right to refuse treatment to the right to refuse psychotropic medications. And I will state unequivocally that present evidence indicates without question that to deny a patient with a major mental illness psychotropic drugs is indeed the same as denying the diabetic his insulin, the hypertensive his antihypertensive agents, and the Addison's Disease patient his life-saving hormones. We can stop arguing about whether psychotropic drugs are useful or not in the treatment of major mental illness. They are useful and necessary. If one assumes, which I think one safely can, that people are not committed against their will to psychiatric hospitals for mere eccentricity, or convenience, but rather with prevailing commitment standards are committed because they are mentally ill, are dangerous, and are in need of treatment, then the field of persons being committed narrows largely, if not entirely, to persons with major mental illness which can be expected to respond to psychotropic therapy. That is not to say that the rest of the tools that a psychiatrist uses in his practice with a broad spectrum of disorders are not useful in this group of patients, but it is to say that the one single modality which is crucial if the patient is to improve is psychotropic medication. One need only look at the two tables attached to be persuaded that anti-psychotic drugs are to schizophrenia, for example, as streptomycin is to pulmonary tuberculosis. In both the case of streptomycin and anti-psychotic drugs, the improvement is striking and irrefutable. Persons treated with placebo only in the case of psychotic patients either became worse or showed no change, or only very minimal change. Persons who were treated with placebo instead of streptomycin either died, showed considerable deterioration, and only few showed some improvement. The overall configuration of the graph is strikingly similar. Figure 2 shows the usefullness of drugs again in patients with major mental illness measured in terms of days in the hospital on

three years follow-up after the first admission. Patients treated with neither drugs nor psychotherapy, or psychotherapy alone, had significantly more days in the hospital over a 36-month period of time than persons treated with drugs alone or persons treated with drugs and psychotherapy. The role of psychotherapy in situational and psychoneurotic difficulties is to deal with specific causes and etiology; the role of psychotherapy in the treatment of major mental illness is to be supportive and constructive in the same way as psychotherapy would be used with other somatic or biological diseases in helping the patient achieve a better rehabilitation. To be sure, psychotropic agents have side effects. So do penicillin, streptomycin, insulin, and all other medications that persons use. To be sure, tardive dyskinesia is a serious side effect. But schizophrenia is a serious life-draining, disabling illness, but clearly, the benefit of anti-psychotic agents, even with their side effects, far outweighs any attendant risks of side-effects, such as tardive dyskinesia. Finally, it is important to realize that mental illness, unlike diabetes, coronary artery disease or hypertension, specifically and selectively does interfere with the judgment of the patient such that the very mechanism, i.e. the use of insight and judgment that would bring the person under care may be interfered with such that the person refuses care. That is the whole basis for involuntary hospitalization. If mental illness did not interfere with the judgment and competency of the person to make proper decisions about his or her care, then there would be no validity for an involuntary hospitalization statute whatsoever.

If one accepts the irrefutable evidence that anti-psychotic drugs are useful in the treatment of major mental illness, and indeed are the specific treatment for major mental illness; and if one can accept the finding that for that person who has a major mental illness the risk of anti-psychotic side effects is outweighed considerably by the benefits of such agents considering the seriousness of major mental illness; and if one can accept the fact that mental illness, by its very

nature, may have a selective effect on the patient such that he or she has such impairment of judgment as not to be able to make considered decisions about whether he or she needs medication or not (i.e. the medication is seen as alien as a part of a delusional system); and if one can accept the fact that hospitalization for treatment without the power to treat is an act of futility, then one must face not whether there should be an absolute right to refuse treatment, but rather, what procedures, alternatives, or possibilities exist to allow on the one hand this specific, useful treatment to be applied, yet provide safeguards against the abuse of such treatment.

There are some alternatives available in this area. The first alternative would be to separate out the decision to be committed from the decision to be treated. The judge could, in all commitment proceedings, separate the commitment decision from the patient's capacity to make treatment decisions. A problem with that alternative is that doing this on a case by case or instance by instance basis is unworkable for the physician, and it is conceivable that one would have to go to court every time a medication needs to be changed, or everytime some new situation presents itself that was not thought of at the time of commitment. For example, one may well foresee the need for the patient to be on psychotropic medication and the judge could make such a determination and finding. But suppose the person developed some independent process during hospitalization, or falls and requires sutures and a tetanus shot, or develops a urinary infection or a whole variety of other possibilities, unless each of these situations were foreseen at the time of commitment, it could be a very time-consuming process to return to court for each of these non-emergent situations and, of course, it would be an unworkable process in the case of emergency treatment. It would seem that for this principle to prevail, the patient's competency to consent to treatment would need to be weighed over and against each and every treatment, rather than a blanket finding that the person is or is not able to make a decision with respect to treatment in general.

The alternative which I prefer, and one which we have used in Wisconsin, is to establish a section of "treater's rights". This procedure is based on the simple presumption that if a person has been committed to a hospital for treatment, and if the cumbersome legal machinery has moved, the patient's rights have been properly protected, due process has been properly observed, and the patient meets whatever commitment standards prevail, then the person is committed for treatment and the person, agency, or facility with the responsibility for treatment can use customary and ordinary treatment procedures toward amelioration of the condition for which the person was committed.

In the present Wisconsin Mental Health Act, portions of which I helped draft, there is an elaborate Patients Rights section outlining eighteen patients' rights including being informed orally and in writing of the rights, the right to least restrictive environment, the right to send sealed mail, receive visitors, etc., etc. There is a section which states the patient has "a right to be free from unnecessary or excessive medication. No medication may be administered to a patient except at the written order of a physician. The attending physician is responsible for all medication which is administered to a patient. A record of the medication which is administered to each patient shall be kept on his or her medical records. Medication may not be used as a punishment, for the convenience of the staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program. The patient may refuse medications and medical treatment if the patient is a member of a recognized religious organization and the religious tenets of such organization prohibit such medications and treatment. The individual shall be informed of his right prior to administration of medications or treatment whenever the patient's condition so permits."[7] You will note that the right is to be free from "unnecessary or excessive medication". Elsewhere in the Mental Health Act cognizance is given to the situation where a person in detention may need emergency

treatment, prior to commitment, and in those instances the individual may refuse medication and treatment "except when there is a life-threatening situation or when such medication or treatment is necessary to prevent serious physical harm to the individual or to others". However, once the elaborate machinery of commitment has moved, and the person is committed "for custody and treatment", then, as enumerated in the Patients Rights section, *"any agency providing services under an agreement with the department or such boards, has the right to use customary and usual treatment techniques and procedures in a reasonable and appropriate manner in the treatment of patients who are receiving services under the mental health system, for the purpose of ameliorating the conditions for which the patients were admitted to the system. The permission of any patient who was voluntarily admitted shall first be obtained. In the case of a minor, the permission of the parent or guardian is required."*[8]

Rather than have the court make an individual judgment in each instance with respect to the patient's need for treatment, I feel that the treater's rights approach is a much more logical, consistent, and workable one. If it is clear that the patient does have a right to be free from unnecessary and excessive medication, and if it is clear that during detention and prior to commitment the facility may use medication in life-threatening circumstances or situations wherein the patient is a clear danger to himself or others, and if after the elaborate machinery of commitment has placed the person properly in the hospital, then at that point the agency should be able to use "customary and usual treatment techniques and procedures in a reasonable and appropriate manner". At that point one has reached then a workable, reasonable middle ground between the right to receive treatment and the right to refuse treatment.

It is my suggestion that rather than determining competency to make treatment decisions on a case by case basis, a treater's rights section be balanced with a

patient's rights section in the manner outlined. If the patient on the one hand is guaranteed the right to be free from excessive and unnecessary medication, and if the agency on the other hand is able to use ordinary and customary treatment in an appropriate and reasonable manner, then I think one has, on this dimension at least, properly, skillfully, humanely, and legally struck a balance in this delicate, emerging, and important area.

I give the Wisconsin approach to this dilemma to you for your consideration.

Dr. Loren Roth points out the oft-quoted statement of John Stuart Mill declaring that "the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant."[9] These two sentences of Mill's assert the primacy of liberty and reject the concept of parens patriae, and are often cited, but a subsequent sentence is seldom mentioned: "It is, perhaps, hardly necessary to say that this document is meant to apply only to human beings in the maturity of their faculties". Apparently from the happenings to this point in the right to refuse treatment, what formerly was "hardly necessary to say" now becomes entirely necessary to say, and hence, my contribution to this search in this one area for that reasonable middle ground that I am convinced we are capable of achieving in the delicate interface between Psychiatry and the Law.

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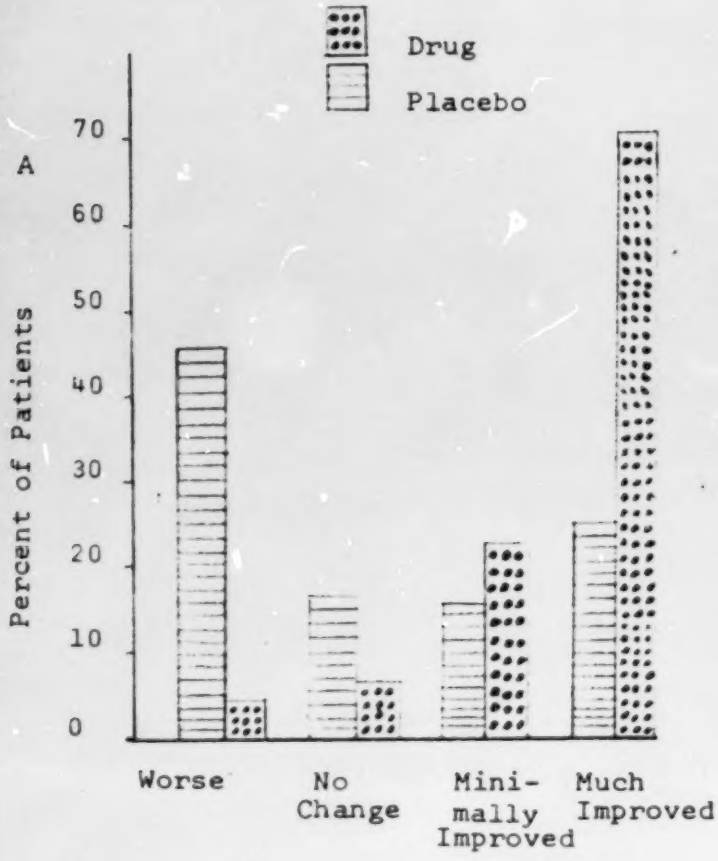
Figure 1

Result of Treatment of Schizophrenic Patients with Antipsychotic Drugs or Placebo



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Therapeutic Effects of Streptomycin with Bed Rest vs. Bed Rest Alone in Pulmonary Tuberculosis

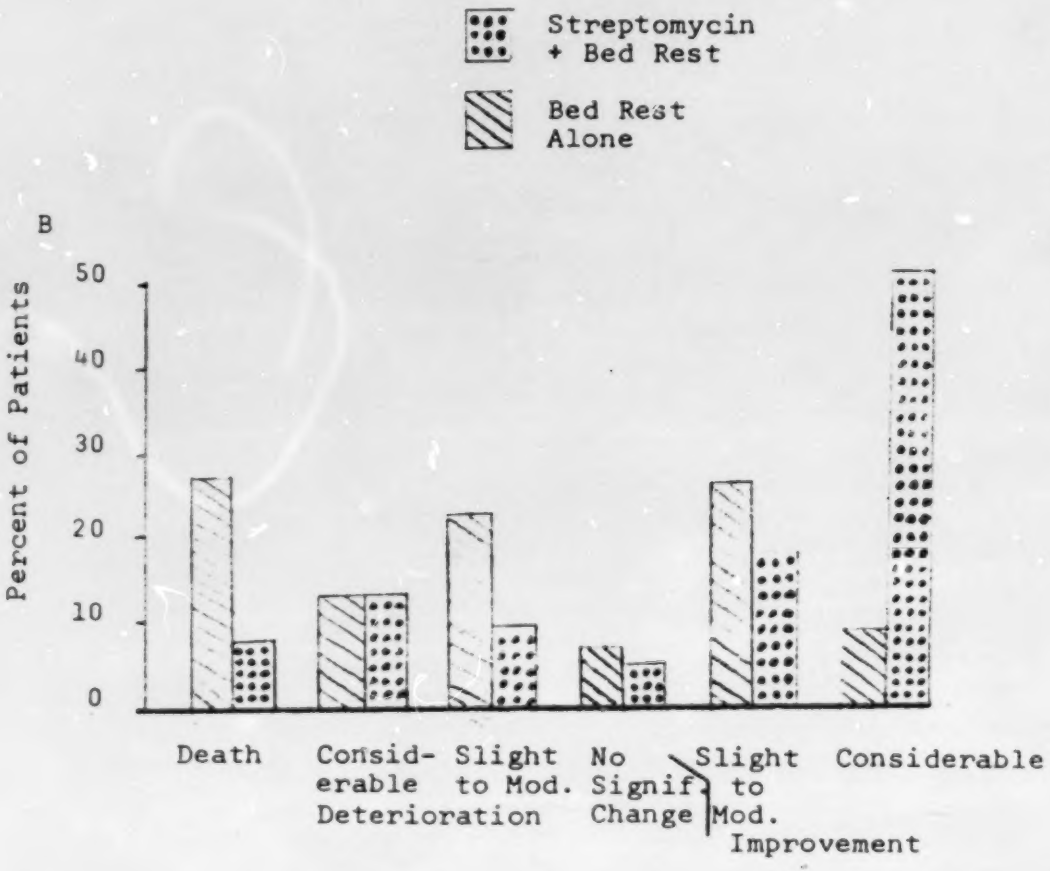

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Figure 2

Days In Hospital At Three Years
Follow-Up From First Admission